Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TWELVE OAKS HOSPITAL
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-98-9167-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was reviewed and it was decided that the carrier should pay Reasonable charges. This has been billed to the carrier on several occasions. They have done several changes in location and claim has been in review since 2-97- not sure what carrier is disputing. Please review for payment."

Amount in Dispute: $ 33,813.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules… This facility is contracted with Liberty Mutual's PPO Healthcare/ Compare Affordable. As per the contractual agreement, reimbursement should be made at the lesser of the PPO per diem rate, the percentage off discount or the amount allowable per state guidelines less 8%. This stay was reimbursed at the reasonable surgical per diem rate of $1100/day for 7 days and 1 ICU day at the reasonable rate of $1600/day. An additional amount of $3093.75 has been allowed for the implants pending receipt of an invoice to verify reasonable payment. The PPO discount has been applied to this amount… Additional reimbursement based on the court decision of 12/6/95 does not appear to be warranted. The inpatient rule was determined void and unenforceable because the Commission failed to satisfy the reasoned-justification requirement of the Administrative Procedure Act. The inpatient per diem rates established by the schedule were not determined unreasonable."

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 1996 to November 27, 1996	Inpatient Hospital Services	$ 33,813.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, Volume 16 *Texas Register*, page 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, Volume 16 *Texas Register*, page 5210, sets out the reimbursement guidelines for the services in dispute.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 25, 1997.
5. The Texas Department of Insurance, Division of Workers' Compensation has been advised that the requestor's hospital facility was included in a River Oak's bankruptcy case in Delaware and that the Chapter 7 trustee, on behalf of the bankruptcy estate, asserted no interest in the pending medical fee disputes for the debtor's hospitals in Texas and that any such interest was transferred or assigned to the General Electric Credit Corporation (GECC), since renamed General Electric Capital Corporation. Therefore, this decision is being sent both to the last known address provided by the requestor in this dispute in accordance with 28 Texas Administrative Code §102.5(b) and to the General Electric Capital Corporation.
6. Neither party to this dispute submitted copies of explanations of benefits or a copy of the notice of medical payment dispute for consideration in this review.

Findings

1. In accordance with the applicable, former version of 28 Texas Administrative Code §133.305(a), effective June 3, 1991, Volume16 *Texas Register,* page 2830, requests for review of medical services and dispute resolution shall be submitted to the Division's medical review office in Austin no later than one calendar year after the date(s) of service in dispute. The request for dispute resolution of services rendered on dates of service November 19, 1996 through November 24, 1996 was received by the Division on November 25, 1997, more than one year after the date of service. The Division finds that the request for dispute resolution was not submitted timely with respect to those services. The Division concludes that the requestor has not met the requirements of §133.305(a). Therefore service dates November 19, 1996 through November 24, 1996 will not be considered in this review. However, the request for dispute resolution of services rendered from November 25, 1996 to November 27, 1996 was submitted in accordance with the timely filing requirements of §133.305(a); therefore, these services will be considered in this review.
2. The respondent's position statement asserts that "This facility is contracted with Liberty Mutual's PPO Healthcare/ Compare Affordable. As per the contractual agreement, reimbursement should be made at the lesser of the PPO per diem rate, the percentage off discount or the amount allowable per state guidelines less 8%." Former Texas Labor Code §408.027(d) [currently 408.027(e)], Texas Civil Statutes, Article 8308-4.68(d), effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee." Former 28 Texas Administrative Code §133.304(a), effective February 20, 1992, Volume 17 *Texas Register,* page 1105, provides that "The report described in the Texas Workers' Compensation Act (the Act), Texas Civil Statutes, Article 8308-4.68(d), shall be named Form TWCC-62, Notice of Medical Payment Dispute." The respondent did not submit a copy of form TWCC-62 Notice of Medical Payment Dispute or any copies of explanations of benefits for review. No documentation was found to support that the insurance carrier sent the required report containing sufficient explanation of the above reason(s) for the reduction or denial of payment to the Division, the health care provider, and the injured employee. The Division concludes that the respondent has not met the requirements of §408.027.
3. Additionally, the respondent failed to provide sufficient documentation to support application of the asserted contracted rate. A copy of the contract was not submitted for review. The submitted documentation consisted solely of a listing of summary changes to the rates of the allegedly contracted hospital without any indication of agreement by the requestor to the alleged rates. The respondent has not supported the applicability of the alleged contracted rates to the services in dispute. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
4. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee

guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, Volume 16 *Texas Register*, page 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."

5. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
6. Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	March 9, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

	Martha Luevano	March 9, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.